Testimony before the Human Services Committee
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Good morning, Senator Lesser, Representative Gilchrest, and distinguished members of the Human Services Committee. My name is Andrea Barton Reeves, and I am the Commissioner-Designate of the Department of Social Services (DSS).

I am pleased to appear before you today to offer remarks on several of the bills on today's agenda.

SB 58 - AN ACT CONCERNING CONSERVATOR COMPENSATION BY MEDICAID APPLICANTS AND RECIPIENTS

This bill proposes to exempt conservator and fiduciary fees from Medicaid income eligibility and asset transfer determinations.

A state Medicaid agency is required to reduce costs to the state by using the member's income (applied income) for payment of institutional services. A Medicaid member's gross income is reduced by all allowable deductions in a specific order defined by the post eligibility treatment of income rules. This process results in a resident liability amount paid directly by the member to the long-term care provider, thereby reducing the amount that the state pays to the provider each month.

Currently, allowable monthly deductions consist of a personal needs allowance established by state law, a community spouse allowance, a community family allowance, Medicare and other health insurance premiums, costs for medical treatment approved by a physician when incurred subsequent to the effective date of eligibility which are not covered by Medicaid, expenses for services provided by a licensed medical provider in the six-month period immediately preceding the first month of eligibility, $90 for a war veteran or spouse of a deceased war veteran with a reduced Veterans Administration Improved Pension, and a deduction of the costs of maintaining a home in the community when expected to return home.

Section 1(a) of this bill proposes to add conservator expenses, including conservator compensation, probate court filing fees and expenses, and premiums for any probate court bonds as additional allowable deductions. It establishes a minimum baseline conservator compensation of $125 per month and would authorize a probate court to allow for a greater amount, despite the fact that Section 16 of the Probate Court Regulations requires the submission of invoices for time expended in increments of one-tenth of an hour; documentation relating to who is performing services; and a summary of the activity for each entry. If passed, this provision would increase the costs of the Medicaid program in several ways.

First, each expense that is deducted from the resident's liability will increase the percentage of costs the state will be liable to pay for institutional services provided to a Medicaid member. In addition to an increase to the Medicaid budget, implementing a change to the Department's resident liability calculation will require numerous system enhancements, as the current eligibility system is not programmed to include conservator and fiduciary fees as an allowable deduction. Such system enhancements, depending on their complexity, can cost several hundred thousand to up to several million dollars.

In addition to the need for system enhancements, the requirement to track and calculate expenses related to conservatorship would impact the long-term services and supports eligibility determination process, requiring additional staff at DSS to ensure compliance with timeliness standards. Section 1(c) requires the Department, on an annual basis, to calculate and inform the Probate Court Administrator of the total amount deducted from applied income under section 1(a) and requires the Probate Court Administrator to transfer one-half of this amount to the Department. While the Department would welcome partial reimbursement of the amounts deducted from individuals' applied income, the task and cost of tracking such data, making necessary system changes, and maintaining the processing workload would fall exclusively on the Department, also requiring additional staff for implementation.

Section 2 of the bill would prohibit the Department from treating any fee or expense approved by the probate court as an improper transfer when evaluating a Medicaid application filed by or on behalf of the conserved person, "provided the applicant or recipient submits documentation to the commissioner demonstrating the services rendered were in accordance with Probate Court regulations and the compensation, fee and expense were for the fair market value of the services rendered." However, it is unclear to what extent the Department could disagree with any Probate Court determination concerning the appropriateness of the amount of the fee paid to the conservator in light of the passage of Public Act 22-112 last session, which would arguably bind the agency to any determination made by the probate court concerning the fair market value of the services rendered.

It is important to note that the Department is the single state agency that determines Medicaid eligibility and must retain discretion to consider whether there has been a transfer of assets for fair market value. Currently, if the Department determines that payment of a conservator fee was made in exchange for the fair market value of the services performed, the payment will not be considered an improper transfer. If, however, the Department concludes that an individual has paid a conservator fee that is excessive and not consistent with the services provided by the conservator, the Department must have the ability to impose a transfer of asset penalty, consistent with state and federal law.

Because portions of this bill are inconsistent with state and federal law and would have a significant negative fiscal impact on the state budget, the Department must oppose this bill. The Department also acknowledges the need for work on this very important issue of adequately compensating conservators who are appointed to individuals with limited resources. The Department welcomes the opportunity to work with the Probate Courts to develop a long-term solution to the issue.

SB 82 – AN ACT ELIMINATING INCOME AND ASSET LIMITS FOR THE MED-CONNECT HEALTH INSURANCE PROGRAM FOR WORKING PERSONS WITH DISABILITIES

The proposed legislation seeks to eliminate income and asset limits for working persons with disabilities to qualify for Medicaid. Currently, the Medicaid program for employed disabled individuals, or "MED-Connect," allows certain Connecticut residents with disabilities who earn up to $75,000 per year to qualify for full Medicaid coverage under HUSKY C. As of January 2023, 3,716 individuals were enrolled in MED-Connect. Individuals above 200% of the federal poverty level pay a premium for the coverage. Currently, 950 MED-Connect enrollees have a premium obligation. MED-Connect also allows eligible individuals to work and retain assets greater than what is allowable under traditional Medicaid coverage groups. The program includes a $10,000 resource test for individuals and a $15,000 resource test for married couples. This resource test excludes home property, certain retirement accounts, ABLE accounts, and accounts maintained for the purpose of increasing employability. MED-Connect also includes the "Medically Improved" group, a coverage component for individuals who have lost disability status through the Social Security Administration, but still have some severe medical impairment. The proposed bill would eliminate the income and asset limits for both groups.

The Department appreciates the intent to expand medical coverage options for working individuals with disabilities. While administrative efficiencies could bring some cost savings, such savings would not be enough to offset the costs of increased enrollment. It is difficult to project the financial impact of the proposed bill as removal of the income and asset limits raises uncertainty as to the number of individuals who may be eligible to enroll but do not qualify under current rules. The Department does not have data about this population readily available to assess. Assuming the 2022 average monthly cost per person of approximately $632 remained constant, even a modest increase in enrollment of 10% would result in state costs of over $1.4 million. The proposed expansion of eligibility without a limit on income or assets is also likely to encourage individuals currently covered through their employers and private insurance to shift to Medicaid due to its broader coverage and lower cost sharing. Thus, the enrollment increase could be far more substantive, resulting in significant costs. For this reason and without the availability of appropriations, the Department cannot support this bill.

SB 411 - AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR PHARMACISTS DISPENSING BLISTER PACK

The proposed legislation seeks to require the Department, to the extent permissible by federal law, to provide Medicaid reimbursement to pharmacists dispensing blister pack medications to Medicaid beneficiaries. The Department opposes this bill as the current dispensing fee paid to pharmacists for prescriptions to Medicaid beneficiaries covers the cost of dispensing the prescription, including blister packaging.

In 2017, the New England States Consortium Systems Organization (NESCSO) contracted with Myers and Stauffer LC, a certified public accounting firm approved by the Centers for Medicare and Medicaid Services (CMS), to perform a study of pharmacy dispensing costs for NESCSO member states, which included Connecticut. The study included pharmacies participating in the

Medicaid program and the methodology used was consistent with CMS guidelines for Medicaid pharmacy reimbursement regarding the components of pharmacy cost that are appropriately reimbursed by the professional dispensing fee of a state Medicaid program. The study considered the cost of all pharmacy types and included all costs of prescription dispensing, including delivery and blister packaging.

Based on the results of the study, the median cost of dispensing, weighted by Medicaid volume, for all pharmacies participating in the Medicaid program, including specialty pharmacies across the six participating New England states (CT, ME, MA, NH, RI, VT) was $10.59. In Connecticut, pharmacists receive a dispensing fee of $10.75 per prescription under Medicaid. This fee reimburses the weighted median cost of dispensing prescriptions to Connecticut Medicaid members inclusive of all pharmacy types and all costs of prescription dispensing, including delivery and blister packaging.

SB 945 - AN ACT FACILITATING SAFE DISPOSAL OF OPIOID PRESCRIPTIONS BY MEDICAID BENEFICIARIES

This proposed legislation requires the Department to reimburse Medicaid-enrolled pharmacists for any safe opioid disposal system simultaneously dispensed by such pharmacist to a Medicaid beneficiary with a prescription for opioids.

While the Department believes strongly in the importance of safe disposal, this bill is opposed as there already exists several options for the safe disposal of prescription medications and over-the-counter (OTC) products.

Many police stations have a **Drop Box Drug Disposal program** allowing individuals the ability to discard their unwanted or unused medicines in special locked boxes any time the police department lobby is open.

Chain pharmacies including CVS, Walgreens and Rite Aid sell, for a small fee, pre-paid mailers for disposal of prescription and OTC medicines. Other pharmacies provide access to free boxes in which to throw away unused prescriptions and OTC medications.

In addition, from time to time and throughout the state, the federal government and/or specific towns or municipalities sponsor a **special collection** site for residents to safely dispose of unused medications.

For these reasons, the Department opposes this bill as it is unnecessary and would result in additional costs to the Department that are not warranted.

SB 946 - AN ACT CONCERNING THE CONNECTICUT HOME-CARE PROGRAM FOR THE ELDERLY

This bill aims to (1) expand access to the state-funded portion of the Connecticut Home Care Program for the Elderly (CHCPE), (2) compensate family caregivers, and (3) authorize and compensate up to two visits by licensed social workers to home care clients.

CHCPE provides home and community-based services to individuals who are 65 years of age or older, are at risk of institutionalization or meet nursing home level of care and meet financial eligibility criteria. Risk of nursing home level of care means the individual requires assistance with critical needs such as bathing dressing, eating, toileting and taking their medication.

CHCPE has four categories and is funded by both state and federal dollars. Categories 1 and 2 are funded by the state, Category 3 is a 1915(c) home and community-based services waiver, and Category 4 is a 1915(i) state plan amendment which receives 50% federal reimbursement.

This bill reduces the cost share from 3% to 2% of the cost of care. This change is not supported as the cost share has already been progressively reduced from 9% to 4.5% in FY 2022 to 3.0% in FY 2023. The Department estimates that reducing the cost share under the state-funded portion of CHCPE will result in additional costs of $415,000.

DSS values and supports the key role that family caregivers have in ensuring that family members can live and participate in our communities. Family caregivers are the foundation of the state's home and community-based systems. However, the proposed expansion to reimburse spouses providing personal care would result in significantly increased costs that are not supported in the Department's budget, therefore the Department opposes this change.

DSS recognizes the contributions of social workers to the health, well-being, and quality of life of older adults. Our older adult population in Connecticut has become more diverse with more complex care needs, financial situations, as well as family support and emotional health needs. DSS estimates that adding up to two visits by licensed social workers to CHCPE clients will increase the annual costs for the Medicaid waiver program by $1.446 million, with a state share cost of $723,000. Additional state only costs of $193,000 are estimated to result under the state-funded portion of the program, resulting in a total state cost of $916,000.

While these program expansions would benefit additional vulnerable older adults, it would require significant additional funding that is not included in the Department's budget and thus the Department cannot support the bill.

SB 947: AN ACT INCREASING THE MINIMUM AMOUNT OF RESOURCES A COMMUNITY SPOUSE OF AN INSTITUTIONALIZED MEDICAID RECIPIENT MAY RETAIN.

This bill proposes to increase the minimum amount of resources that the community spouse of an institutionalized Medicaid recipient may retain from $50,000 to $60,000.

Currently, community spouses of long-term care Medicaid recipients are allowed to keep one half of the couple's countable assets up to the federal maximum of $148,620. If total assets are under $50,000, the community spouse may now keep all the assets. Prior to July 1, 2022, community spouses were allowed to keep up to the federal minimum or half the amount up to the federal maximum. Legislation was passed last session that raised the minimum amount from the federal minimum ($27,480 at the time) to the current $50,000 threshold. The couple's home and one car are excluded from the assessment of spousal assets.

This bill also requires the Department to report, not later than July 1, 2024, on the impact of increasing the minimum community spouse resource allowance for the fiscal years ending June 30, 2023, and June 30, 2024. The current law requires the Department to report, not later than July 1, 2023, on the change from the prior limit (aligned to the federal minimum) to the current $50,000 threshold. It is recommended that no revisions be made to the minimum amount of resources a community spouse may retain until that initial analysis is complete. Further, adjusting the reporting date to account for an additional year of data does not raise concerns, but the Department would like to take the opportunity to recommend allowing more than one day for the compilation and reporting out on a year's worth of data as the current requirements (pursuant to section 235 of Public Act 22-118) and those proposed under this bill are not feasible. The Department recommends that the dates be revised such that any reporting on the prior fiscal year is to be completed by January 1st in order to allow the Department sufficient time to compile, analyze and report on the prior year's data.

The Department projects that increasing the minimum amount of resources a community spouse may retain from $50,000 to $60,000 would result in an annual cost of approximately $700,000, with a state share cost of $350,000. As this cost is not currently included in the Department's budget and given that the Department is unable to fully analyze the impact of the changes that were made effective this fiscal year, the Department is unable to support this proposal.

HB 5321: AN ACT ESTABLISHING A STATE OMBUDSMAN'S OFFICE FOR BEHAVIORAL HEALTHCARE COVERAGE

The proposed bill would establish a new behavioral health ombudsman's position to make recommendations to Medicaid and other insurance carriers on fair and equitable reimbursement for small and group behavioral health care providers.

While ombudspersons play an important role in the healthcare and social service system, the enacted budget included funding for a position at the Office of Healthcare Advocate (OHA) related to behavioral healthcare services. DSS would respectfully recommend that the legislature analyze the impact of this position at OHA before proceeding with this new office which may be duplicative of the work at OHA.

For this reason, the Department recommends postponing action on this bill at this time.

HB 5765 AN ACT CONCERNING COMPENSATION OF FAMILY CAREGIVERS IN MEDICAID WAIVER PROGRAMS ADMINISTERED BY THE DEPARTMENT OF DEVELOPMENTAL SERVICES

This bill aims to ensure that family caregivers, including but not limited to legally responsible relatives of Medicaid members served by the Department of Developmental Services waivers, can be paid to provide the member with personal care to the extent permissible under the Medicaid program.

The Department of Social Services (DSS) values and supports the key role that family caregivers, including legally responsible relatives, have in ensuring that family members can live and participate in our communities. Family caregivers are the foundation of the state's home and community-based systems.

As you know, in the context of Medicaid, a waiver is a formal agreement between the state and federal government. When a state elects to pay family caregivers and/or legal guardians, states are required to specify state policies concerning making payment to the family caregiver and/or legal guardian for the provision of waiver services. In response to this requirement, DDS waivers specify that a prior approval process must be followed to ensure all other options for the provision of these supports have been explored. This process is used on a case-by-case basis for those circumstances that prove to be extenuating or challenging from a staffing perspective.

DSS does not support amendment of DDS waivers to change existing policies, which ensure safety and health requirements. In addition, this bill would result in additional costs to the state that have not been budgeted and thus the Department must oppose the bill.